LYNN PUBLIC SCHOOLS
SCHOOL HEALTH SERVICES
Prescriber Authorization for Medication Administration in Schools

MEDICATION ORDER FORM

To be completed by a Licensed Prescriber: Physician, Nurse Practitioner or other authorized by Chapter 94C

Date of order_____ Discontinuation date_____
A new order is needed at the start of every school year

Name of Student _____Date of Birth_____ Sex_____

Address_____ School_____ Gr/Rm #_____

Name of Licensed Prescriber_____ Title_____

Business Telephone # _____Emergency # _____

Medication _____ Route of Administration_____
A separate form must be completed for each medication

Dosage_____ Frequency_____ Time(s) of Administration_____
Whenever possible, medication should be scheduled at times other than school hours.

Specific direction or information for medication administration:

_____

_____

Diagnosis*_____ Any other medical condition(s)*_____

Allergies*_____

**If not a violation of confidentiality*

Optional Information:

Special side effects, contraindications, or possible adverse reactions to be observed:

_____

Other medication being taken by the student_____

The date of next scheduled visit or when advised to return to the Prescriber:_____

Signature of Licensed Prescriber_____ Date_____